COSA Benefits Program Forms

The book marked forms can be printed individually by clicking on File/Print... and indicating in the print window the proper Print Range (i.e. "Page From: 8 to 9").

CLAIM FORM



City of San Antonio Employee Benefit Program Statement of Medical Claims

PARTICIPANT'S STATEMENT (COMPLETE FOR ALL CLAIMS)

Employee's Name (Last, First, Middle)		Employee Social Security #	Employee Birth Da	te Claim is for: Self Dependent
Employee's Address (City,	State & Zip)		Phone Number	□Male □Single □Female □Married
Claim is for an illness	For accident claims the following info How accident happened?	ormation <u>MUST</u> be provided	Da	te and time of the Accident.
□Claim is for an accident	Where the accident happened	Is acc	ident related to: Auto □Yes □No	
	TO BE COMPLETE	D IF CLAIM IS FOR I	DEPENDENT	-
Name		The second secon	The state of the s	Spouse employed?
☐ Unmarried child (Birth☐ Unmarried Student Student Student (name of student student attending (name of student attending (name of student attending (name of student attending student attendi	19 years old) of High School, College or University)	If yes, full name of hea	f for health insurance with th plan, phone number and	their employer? Tes No policy number:
	OTHER I	INSURANCE INFORM	NOITAN	
ts there any other insurar address and policy numb	nce coverage available from any other per:	source? □Yes □No If ye	s, full name of health plan o	or insurance carrier, full
AUTHORIZATION TO RI I hereby authorize any in	surance company, prepayment organi	ization, employer or provider	of medical services to relea	se all information to Employee
payable under this or any	other plan providing benefits or servi	ce. I certify that the above in	formation given by me in su	e a bearing on the benefits
payable under this or any	other plan providing benefits or servi	ce. I certify that the above in	formation given by me in su s the original.	e a bearing on the benefits
payable under this or any correct. A photostatic content. Employee signature	other plan providing benefits or serving of this authorization shall be considered the considere	ce. I certify that the above in dered as effective and valid a Claimant signature	formation given by me in su s the original.	pport of this claim is true and Date
payable under this or any correct. A photostatic confect. Employee signature	other plan providing benefits or servi	ce. I certify that the above in dered as effective and valid a Claimant signature	formation given by me in su s the original.	e a bearing on the benefits pport of this claim is true and Date

HOW TO FILE A CLAIM

Submitting Bills

All bills MUST be itemized and include the following:

- (1) Employee's name, social security number and the name of the Claimant
- (2) Name, address, telephone number and TIN# of the Provider
- (3) Date of service, procedure provided, diagnosis for any claims related to an illness or injury

PLEASE

- (1) Do not send cancelled checks or receipts of payment, they WILL NOT be accepted
- (2) Do not submit bills prepared by you. The actual provider's bill will be needed.

WHERE TO FILE A CLAIM

All Claims Are To Be Mailed To:

All Questions Regarding Claims/Benefits

City of San Antonio EBA/USC

Please call: EBA, Inc. (210) 253-2002 (800) 478-3845

P. O. Box 100990 San Antonio, TX 78201-8990

(800) 478-3845 (210) 738-1448 Fax

Electronic Billing to: THIN#-USC11

Visit USC website to locate your Doctor: www.USCHealth.com

CITY OF SAN ANTONIO EXTENDED SICK LEAVE PROGRAM

Mail this form to:

THIS FORM MUST BE RECEIVED
BY THE PLAN ADMINISTRATOR
WITHIN 30 DAYS AFTER ONSET
OF THE DISABILITY. NO BENEFITS
WILL BE PAID IF THIS FORM IS
RECEIVED AFTER 30 DAYS.

Rosie Perez Human Resources Dept. P.O. Box 839966 San Antonio, Tx. 78283-3966 Ph. # 207-7291 Fax: 207-2176

DOCTOR: The ordinance establishing the City's extended sick leave plan requires that the employee be under the care of a licensed physician. This form is necessary for the City to properly administer its extended sick leave payments. The <u>employee will not be paid</u> until this form is completed and filed with the Human Resources Department. We appreciate your cooperation.

1.	Patient's Name: Last	First	Middle
	Date of Birth: Month	DayYear	
	Date first consulted for the of last treatment: Month		Day Year
	I hereby certify that this disabled from his/her regu/because of:	patient was totally and	
	(ICDA Code)	Specific Diagno	osis)
The	MonthDay_	part-time or light duty	/ On:
4.	If pregnant, estimated date	e of confinement:/	//_
5.	REMARKS: (Provide addition disability. Also, indicate		
6.	Surgery Date://_		
	(Date)	(Physician's Signat	ture - no stamps)
Phy:	sician's Name:	Street Address:_	
	y:State: payer I.D. Number:)

Neither the City of San Antonio nor its representatives are responsible for any charges incurred for preparation of this report.

United Dental Care Companies

Please complete thi	is form by printing	in ink or typing.			(Shaded areas fo	
Effective Date:		Site:		Group Number: (Required)	Agent: (If A	pplicable)
Nama				Social Security #:		
Name: Last		rirst	Middle	Social Security #.	(Required)	
				V : 10	D Od	
Address: Number		Street		Marital Status: ☐ Married ☐ Singl	e U Other	
T, danie				Home Phone: ()		
City	State		Zip	Work Phone: ()		
Type of Plan you a	re enrolling in:	Prepaid / Dental H	MO* □ Point-o	f-Service*		
			(PO			
Name of Plan: *All Prenaid and l		nrollees must selec	t a Family Dentis	t from the Dental Directory.		
		mbers listed below:	V II I III I I I I I I I I I I I I I I	o at om two Dental Bil colory.	Sex	Date of Birtl
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Spouse:	First		DDS:	ID#	OM OF	
Last Child:	First	Middle	DDS:	ID#	ом оғ	
Last	First	Middle		ID#		
Child:Last	First	Middle	DDS	ID#	I am ar	
Child:Last	First	Middle	DDS:	ID#	OM OF	
Child:			DDS:	ID#	OM OF	
Last	First			n 4 6		
if additional space		re children please : Information	attach another en	Dependent I	nformation	
Company Name:				Bepondent 1	mormation	
				If dependents are over age 19 please	answer:	
				Are dependents full-time students?	☐ Yes ☐ N	lo
Date of hire:		/(Req	uired)	TC * C - 1 1(2)		
s vour snouse cove	ered for dental at h	is/her place of emple	ovment?	If yes*, name of school(s)		
Yes No		is not place of emp.		*Attach a copy of student's school I.	D.	
f Yes, Employer's	Name:			Do you provide primary support?	☐ Yes ☐ N	ĺo.
If yes, Insurance Ca	arrier's Name:			Is your dependent married?	☐ Yes ☐ N	lo .
elect not to have co	verage for myself o	r dependents and I he	reby waive coverag	e under the above mentioned plans.		
	•	-	•	e:		
_		low and place signatu				
·		• , •	• •	· ·		
 I hereby apply required as my 		ne Plan for myself and	for any eligible depe	ndents listed, and authorize my employer orga	nization to make dec	ductions, if any,
. I agree, for my	self and for any eligi		to abide by the rules	and regulations of the Plan and the terms and o	onditions of the Gro	oup Dental Service
I authorize any	his shall be part of the licensed dentist, phy	sician, hospital, or oth	er health care provid	er to furnish the Plan with such dental or medi	cal information, per	mitted by law,
about myself at I represent that	nd any eligible deper	idents listed as may be	required. I understa	and that any eligible dependents and I agree rer nowledge. I understand that my coverage and	nain members of the	Plan.
provide comple	ete and accurate infor	mation. I will prompt	ly advise the Plan an	d my employer of any changes in this informat	tion.	
. Point-of-service	e enrollees have brol	cer coverage and tradit	ional dental coverage	e for services and supplies not obtained throug	h the Plan-affiliated	network dentist.
Please note: Any percontaining any mate	rson who knowingly rially false informat	and with intent to de	efraud any insuranc y fact material ther	ce company, or other person who files an ap eto commits a fraudulent act, which is a crii	plication of statemene.	ent claim
Ohio Residents – Un	der Ohio State Law	you have the right to ca	incel or terminate thi	is agreement within 72 hours after applying. If plication will be canceled.		ate after having
		_				
Signature:			Date:			



Aetna Life Insurance Company Group Insurance 151 Farmington Avenue Hartford, CT 06156-7350

Empl	oyee	Hire	Date
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Employee Social Security Number

BASIC

Employer Name	City, State	Control Number		Sex
City of San Antonio	San Antonio, Texas	# 701577	☐ Male	F emale
Employee Name (First, Middle Initial, Last)	Birthdate (MM-DD-YY) Marital		Status	
		☐ Married	☐ Single	☐ Other
Employee Base Salary		Telephone Numbers		
		Home ()	-	
\$		Work ()		
Beneficiary Information				
Beneficiary Name (First, Middle Initial, Last)				
Primary	Relationship	Contingent	Rela	tionship
1		1		
SSN		SSN		
2		2		
SSN		SSN		
I certify that all of the information on this form is true an Plan of insurance contained in the group policy and sum				
date of insurance for myself is subject to my being activ my Employer to arrange for the issuance of Group Life C	ely at work on that date and is als	so subject to the health condition requirements of	the Plan, Further, I request	
earnings.	overage for mineri rain or may b	desire engine for and to authorize deductions of t	ne required continuous in	on my
Employees or Authorized Person's Signature (Required)		Date Signed		

City of San Antonio Employees

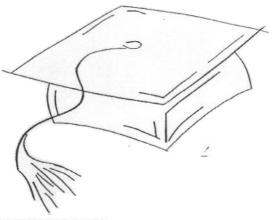
Enrollment Group Life Insurance

Aetna US Healthcare Group Insurance 151 Farmington Avenue Hartford, CT 06156-7350

Employer Name	City, State	Control Number	Employee Hire Date		
City of San Antonio	San Antonio, Texas	#701577			
Employee Information			Employee Social Security Number		
Employee Name (First, Middle Initial, Last)	Birthdate (MM_DD_YY)	Sex	Marital Status		
		☐ Male ☐ Female	☐ Married ☐ Single ☐ Other		
Employee Base Salary	Supplemental Life Amount	"Note: If additional Term Life Insurance is selected,	Telephone Number:		
	☐ 1 x Salary	evidence of insurability will be required for current employees who increase their	Home ()		
\$	□ 2 x Salary	additional life coverage or who enroll for additional life coverage for the first time,	Work ()		
	☐ 3 x Salary	contact the City of San Antonio Employee Benefits Office for information,			
Beneficiary information	Beneficiary Nam	ne (First, Middle Initial Last)			
Primary	Relationship	Secondary	Relationship		
1		1			
SSN#		SSN#			
2		_ 3			
I certify that all of the information on this form is true a	and complete to the best of my knowled	ge and belief. I understand that this insurance	a is subject to all of the terms of the		
Plan of Insurance contained in the group policy and s	summarized in the announcement materi	ials provided me and the certificate issued to r	me. I understand that the effective date		
of insurance for myself is subject to my being actively arrange for the Issuance of Group Life Coverage for v	y at work on that date and is also subject which I am or may become eligible for ar	t to the health condition requirements of the P nd to authorize deductions of the required con	Plan. Further, I request my Employer to additions from my earnings.		
Employees or Authorized Person's Signature (Require	red)		Date Signed		

If your election <u>exceeds</u> either \$150,000 or 2 x's your annual salary please contact the Benefits Office to complete the Evidence of Insurability Form.

CITY OF SAN ANTONIO
EMPLOYEE BENEFITS DIVISION
PO BOX 839966
SAN ANTONIO, TEXAS 78283-3966
(210) 207-8705
ENROLLMENT VERIFICATION



School Name:	Student:
Address:	Social Security
City:	
State/Zip:	

Dear Registrar:

Please complete this form for the above named <u>student.</u> Your assistance is appreciated

this certifies that					SSN	
is enrolled at:		-	ed.			
for quarter or Sen	ester ch	ecked:	Winter			
			Spring			
			Summer Fall			
			rall			
From	/		To:		1	1
Number of Units Full Time Status Signature		Yes	To:	No		1

For Office Use Only:

dependent of	



CITY OF SAN ANTONIO

2003 Benefits Enrollment Form Non-Uniformed Employee

(Last, First, Middle Initial)			98.00	
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/ork Phone:				
ocial Security No:				
ate of Birth: Hire Date:				
n case of emergency contact:				
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Phone:				
lelationship:				
	nose an HMO plan	Protective De	ental, and/or Additio	nal Term Life
Insurance, atlach enrollment form. MARITAL STATUS II. COVERAGE LEVEL 1 Single 1 Employee Only	III. MEDICAL	- alth PLan	IV. DENTAL	OFF USI ON SCI
MARITAL STATUS II. COVERAGE LEVEL	III. MEDICAL	- alth PLan	IV. DENTAL	Sci
MARITAL STATUS II. COVERAGE LEVEL 1 Single 1 Employee Only 2 Married 2 Employee + 1 Dependent	III. MEDICAL	- alth PLan	IV. DENTAL O None CitiDent	Sci
MARITAL STATUS II. COVERAGE LEVEL 1 Single 1 Employee Only 2 Married 2 Employee + 1 Dependent 3 Divorced 3 Employee + 2 or more	III. MEDICAL	alth PLan First Iment form) VIII. REIMBU	IV. DENTAL O None CitiDent	Solution Aurantal Aurantal Res
MARITAL STATUS II. COVERAGE LEVEL 1 Single 1 Employee Only 2 Married 2 Employee + 1 Dependent 3 Divorced 3 Employee + 2 or more 7. VISION (Cole) INSURANCE (Aetna) 0 None 0 None	III. MEDICAL 1 CitiMed Hea 2 Community (attach HMO error VII. LONG TERM DISABILITY 0 None	VIII. REIMBU	IV. DENTAL O None CitiDent Protective De (attach errollment for the contribution)	Solution Aurantal Aurantal Res
MARITAL STATUS II. COVERAGE LEVEL 1 Single 1 Employee Only 2 Married 2 Employee + 1 Dependent 3 Divorced 3 Employee + 2 or more V. VISION VI. ADDITIONAL TERM LIFE (Cole) INSURANCE (Aetna)	III. MEDICAL 1 CitiMed Hea 2 Community (attach HMO enrol	VIII. REIMBU	IV. DENTAL O None CitiDent Protective De (attach enrollment for	Sciental August Process
Insurance, attach enrollment form. MARITAL STATUS II. COVERAGE LEVEL 1 Single 1 Employee Only 2 Married 2 Employee + 1 Dependent 3 Divorced 3 Employee + 2 or more 7. VISION VI. ADDITIONAL TERM LIFE (Cole) INSURANCE (Aetna) 0 None 0 None 1 Yes 1 1 x Annual Salary (attach enrollment form)	III. MEDICAL 1 CitiMed Hea 2 Community (attach HMO error VII. LONG TERM DISABILITY 0 None	VIII. REIMBU	IV. DENTAL O None CitiDent Protective De (attach errollment for the contribution)	Scale of the state
Insurance, attach enrollment form. MARITAL STATUS II. COVERAGE LEVEL 1 Single 1 Employee Only 2 Married 2 Employee + 1 Dependent 3 Divorced 3 Employee + 2 or more 7. VISION VI. ADDITIONAL TERM LIFE (Cole) INSURANCE (Aetna) 1 Yes 1 1 x Annual Salary (attach enrollment form) 2 2 x Annual Salary (attach enrollment form)	III. MEDICAL 1 CitiMed Hea 2 Community (attach HMO error VII. LONG TERM DISABILITY 0 None	VIII. REIMBU	IV. DENTAL O None CitiDent Protective De (attach enrollment for	Sciental August Process



SECTION 3. Enter all dependent information below.

	gal Guardian of Child (attach legal documentation) BIRTH DATE RELATION CODE SOCIAL SECURITY NUMBER
	DINTIPATE RECEIVED TO THE PROPERTY OF THE PROP
1.	No. of the second secon
2	Special Estate Control and Con
3	Date of Size
4	the Manual Table of the Annual Control of th
5	Riones
6	Retallations
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11	ASSOCIATE THE PROPERTY OF THE
12.	CALES TO SERVICE TO SE
If spouse is employed by the City or any othe	r employer, please write the name of the employer and phone number below. Phone Number:
SECTION 4. Read carefully, sign, date, and re	elurn the form to your department's payroll clerk.
for 2003 and understand that my election ca further understand that I can only make chan legal documentation. This change can only b	the City of San Antonio Benefits Program. I hereby make my election of benefits innot be changed once this form is received by the Employee Benefits Office. I ages in dependent coverage (i.e. newborn, adoption, marriage, divorce, etc.) with e done in person at the Employee Benefits office and only within 31 calendar days il deductions that may result from my elections.
981.10(10 mesos on 2 million 10)	
Employee Signature	Date COSA FORM CFX031

Community First Health Plans Enrollment Form

	4801 N	nunity First Ho .W. Loop 410 n Antonio, TX	, Suite 1000	6 - 11 - 12 - 12	(For office use only)	Group Number: Effective Date:			Acres and the second	e or Small High		to doclare coverage. I and to the terms and coverage by the terms and coverage by the Europeyers	
Company Name: Employee Social Security #: Employee Date of B					E L C N LMCD LCC							l:	
									****	(2) nebeself witig			
Home Phone #:	Kelaty	Work Phone #:		Street Address, City,	ddress, City, State, Zip:						County:		
()		()			street nauress, city, state, kip.							essent de Jones (avec es	
Marital Status: Single Divorced	Marrie		Plan Choice: HMO DEPO	Type of Coverage Des		■ Employee & One	■ Employee & Ch	ildren (EE ⊣	⊢ 2 or more)	☐ Family	Home E-mail (C	Optional)	
Date of Full-time Employment:	Do you have	e other health ge? 🔲 Yes 🔲 No	If YES, Name of Carrier:				Policy Number:			Group Nu	nber:		
			DROWING THE FOLL	DIVING INFORMAT	ION FO	R ALL PERSONS TO B	E COVERED (INC	LUDING AD	DI ICANT\			who is the in the come	
Full Name Relation to Employee		Date of E	erth PCP (Prima	ry Doctor) Primar	y Dentist	OB/GYN (for women – if applicable)	Court Order to cover?	Full-Time Student?	Physical and/o	n Specify Prim	. corciage.	If Yes, Name of Insurance Company	
		Social Se	#	(11 ap)	pincable	п аррисамс)	Y/N	Y/N	Disability? Y/	N Canguage	Y/N		
Employee:		DOB: SSM:											
Spouse:		DOB:								TO LOS OPENS			
		SSN:											
Dependent I:		DOB:											
Relationship:		SSN:											
Dependent 2:		DOB:											
Relationship:		SSN:											
Dependent 3:		DOB:											
Relationship:		SSN:											
Dependent 4:		DOB:											
Relationship:		SSN:											
YES, I wish to enroll in t I have read, or have had changes the risk assume Member Rights & Respon	read to me, a d by this plan	all information contai , I may lose coverage	ned in this form and it is ac under this plan. I also und	e of the premium. I a curate and complete t	uthorize to the bes	st of my knowledge. I und	o me or my depende lerstand that if I hav	re made any n	naterial false st	itement, misrep	resentation or omi:	ssion on this form which	
			MAINER OF COVERA	CE //f you choose got t	to oproll-in	Community First you must o	charle the how halour as	ad road rouges	cide and cian				
NO, I do not wish to enr	oll in Commu	nity First Health Plans								rse side of th	s form.)		
						SIGNATURE							
Employee Signature:					,	SIGNATURE		Date					

CFHPUHSENROI.DOC White: Community First Copy

Yellow: Employer Copy

Pink: Employee Copy

		高级的运动市场建筑和政策和发展	WAIVER OF COVERAC	iE .				
stated in the space provided the reason	for declining cover by declining cover	coverage under the Certificate of Group Health Care Co erage. My eligible dependents and I were not induced age my eligible dependents and I may be excluded from ealth Care Coverage.	or pressured by an emplo	yer, an agent, or Communi	ty First Health Plans, Inc. until the next annual ope	into declining such	coverage but have and that, upon e	e elected of our own accord
Eligible Employee:				31		1 Sci 'omioni		
š Yhddh Imoal:								
Eligible Dependent(s):								
Country			. igi					
Reason for Declining Coverage:						()		
State E-mail (Optional)		Employee & Children (EE + 2 or more)		Type of Coverage Desired: Employee only	Plat Cloice:			
Signature of Eligible Employee:	l same cons	GELGAVE GELVALUDDING AS PLICARD		T MOTARIAGRALIANIY	Date:		l mi i	equil (sel

CLAIM FORM



City of San Antonio Employee Benefit Program **Statement of Dental Claims**

PARTICIDANT'S STATEMENT (COMPLETE FOR ALL CLAIMS)

Employee's Name (Last, First, Middle)			Employee Social Security #		Employee Birth Date	Claim is for: ☐Self ☐Dependent	
Employee's Address (City, State & Zip)			(all and all all all all all all all all all al		Phone Number	□Male □Single	
						□Female □Married	
Claim is for a dental	For accident claim How accident hap		formation <u>MUST</u> be provided	-	Dat	e and time of the Acciden	
accident	Where the accider	nt happened				ent related to:	
					Job □Yes □No	Auto □Yes □No	
	TO BE	COMPLETED	DIF CLAIM IS FOR D			1870072	
Name			Date Of Birth S	ex		pouse employed? Yes No	
☐ Unmarried child (Birth ☐ Unmarried Student Student attending (name		ge or University)	Is your Spouse covered If yes, full name of heat			eir employer?□Yes □No policy number:	
		OTHER IN	NSURANCE INFORM	IATIO	N		
AUTHORIZATION TO R	ELEASE INFORMAT	ION repayment organiz	ource? Yes No If ye		out the Americans III	s to release all information	
to Employee Benefit Adi	ministrators Inc. or th	neir authorized rec	presentative, with respect to	myself (or my dependents, wh	nich may have a bearing o	
the benefits payable und	ministrators, Inc. or the	neir authorized repolan providing ben	oresentative, with respect to efits or service. I certify that ion shall be considered as e	myself of t the ab	or my dependents, wt ove information given	nich may have a bearing of by me in support of this	
the benefits payable und claim is true and correct Employee signature	ministrators, Inc. or the this or any other part. A photostatic copy	neir authorized repolan providing benoof this authorizati	presentative, with respect to efits or service. I certify that ion shall be considered as e	myself of the ab	or my dependents, whove information given and valid as the origin	hich may have a bearing of by me in support of this hal. Date	
Employee signature AUTHORIZATION TO R I hereby authorize Employee	ministrators, Inc. or the this or any other part. A photostatic copy	neir authorized repolan providing benoof this authorizati	presentative, with respect to efits or service. I certify that ion shall be considered as e	myself of the ab	or my dependents, whove information given and valid as the origin	nich may have a bearing of by me in support of this nal. Date	
Employee signature AUTHORIZATION TO R I hereby authorize Employee services received. Employee signature	ministrators, Inc. or the this or any other part. A photostatic copy	neir authorized repolan providing ben- of this authorizati TO PROVIDER rators, Inc. to release	presentative, with respect to efits or service. I certify that ion shall be considered as e Claimant signature as e payment of benefits to the	myself of the ab	or my dependents, whove information given and valid as the origin cian, supplier, or med	Date	
Employee signature AUTHORIZATION TO R I hereby authorize Employee signature Employee signature CHE	ministrators, Inc. or the this or any other parts. A photostatic copy EELEASE BENEFITS byee Benefit Administration of the thin t	TO PROVIDER rators, Inc. to release to fall recommers the recommers to fall recommers the recommers to charge for each	cresentative, with respect to efits or service. I certify that ion shall be considered as e Claimant signature as a payment of benefits to the Spouse signature of the considered strains and the considered as a service of the considered as a servic	timate al Sei	or my dependents, whove information given and valid as the origin cian, supplier, or med	Date Date Date	
Employee signature AUTHORIZATION TO R I hereby authorize Employee signature Employee signature CHE If the cost of treatme must indicate:	ministrators, Inc. or the this or any other parts. A photostatic copy EELEASE BENEFITS EYEN BE	TO PROVIDER rators, Inc. to release to fall recommer charge for each ovide supporting	Claimant signature Spouse signature St's Pre-treatment Esst's Statement of Actu O, a pre-treatment estimemended dental proceduch procedure and	timate al Sei	or my dependents, whove information given and valid as the origin cian, supplier, or med arvices	Date Date The physician or deni	

Employee Benefit Administrators, Inc. P O Box 100990 San Antonio, TX 78201-8900

Please Call: (210) 253-2002

(800) 478-3845

(210) 738-1448

PE OR PRINT	OVEE	CHEC	PIDED) IN	FORMA	TION	With the last of t		1000					E IS COMPLETE
ATIENT & EMPL				2. Patient's Date of Birth			3. Employee's Name (First name, midde initial, last name)						
Patient's Address (Street, ci	ity, state, Z	ZIP code)		5. Patient's Sex 5. Employee's I.D. Medicare and or N				nd or Medicald No	. (include any letters)				
		Male Female											
				7. Patient'	s Relationsh		mplayee	8. E	mploy	ee's G	roup No. (Or I	Group Name)	
				Setf	Spouse	Child	Other				18 WE		
other Health Coverage — Enter Name of Planholder or policyholder					on Related To 11. Employee's Address (Street, city, state, ZIP code)					(ebo)			
and Plan Name and Address and Policy or Dental Assistance Number				nt's Employ	ment	٦							
				Yes	1		No						
				B. An A	uto Accider	nt -	No						
					Secretary and the second						- t C C	Samueland Auth	advetion Does No
2 - 13. I Authorize Payme Extend to Benefits	ent of Med	dical Benefit	ts to Undersigne	d Dentist of er Form is F	Supplier fi Released By	or Ser v Prov	vices Desci ider.	ibed B	elow	as Ha	ving Been C	ompreted. Auth	Orization Does not
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ENTIST OR SUP	PPLIER	INFOR	MATION	(1//se./1/)		22	ls Treatment	Result		Yes	f Yes, Enter B	rief Description an	d Dates
. Dentist						44	of Occupatio	nal			/ 100mm40 m210 m2100		
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. Mailing Address							of Auto Acci	dent?				No.	Section Committee on the Committee of th
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CITY, STATE, ZIP							Covered By Another Plan	7					
6. Dentist Soc. Sec. or T.I.N.	17 Denti	ist License Ne	o. 18. Dentist Ph	ione No		26.	If Prothesis,			1	III No, Reason	For Replacement	
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SIGNED (DENTIST)

MAIL CLAIMS TO: Employee Benefit Administrators, Inc. P O Box 100990 San Antonio, Texas 78201-8990

DATE

EBA/USC P.O. Box 100990 San Antonio, TX 78201-8990 210-253-2002 or 1-800-478-3845

FLEXIBLE SPENDING PLAN CLAIM REQUEST FORM

Please type or print clearly - Completed form must be mailed intact with attached appropriate forms. SEE REVERSE SIDE FOR ADDITIONAL INFORMATION AND REQUIREMENTS.

PARTICIPANT NAME	SOCIAL SECURITY NUMBER	EMPLOYER NAME
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PARTICIPANT MA	ILING ADDRESS	CITY, STATE AND ZIP
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HEALTH CARE EXPENSE REIMBURSEMENT REQUEST

Proof of expenses must be attached. You must submit a statement from the provider showing the name and address of the service provider, the date services were performed, type of service(s) and amount(s) charged. If the eligible expense(s) are covered by another medical, dental or vision plan, you may submit the Explanation of Benefits, which details amounts paid and not paid by the benefit plan as proof of expense(s). All available insurance benefits must be utilized before you can claim expenses from your Health Care Spending Account.

	Name of Service Provider or Description of Expense	Name of Eligible Dependent or "Self"	Relationship or "Self"	
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		Total Eligible Health Care Ex	penses	S

I certify that I am familiar with and understand the Plan requirements contained in the Summary Plan Description; that the amounts herein requested for reimbursement have actually been incurred as eligible Plan expenses during the Plan Year and that these expenses have not, cannot and will not be reimbursed to me in any other form, be deducted on my income tax return, nor were they previously submitted for reimbursement under this or any other plan.

PARTICIPANT SIGNATURE	DATE
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DEPENDENT DAY CARE EXPENSE REIMBURSEMENT REQUEST

Proof of expenses must be attached and must include dates of services, the providers employer identification or social security number, and the address of the provider. Proper completion of the following information will be considered proof of expense.

Name and Address of Provider	Provider's Taxpayer Identification Number	Name/Age of Qualified Dependent	Relationship	Eligible Expense
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	Name and Address of Provider			Name and Address Provider's Taxpayer Name/Age of Identification Number Qualified Dependent Relationship Total Eligible Dependent Care Expenses

I certify that I am familiar with and understand the Plan requirements contained in the Summary Plan Description; that the amounts herein requested for reimbursement have actually been incurred as eligible Plan expenses during the Plan Year, and that these expenses have not, cannot and will not be reimbursed to me in any other form, be used to calculate a tax credit on my income tax return, nor were they previously submitted for reimbursement under this or any other plan.

PARTICIPANT SIGNATURE	DATE

PARTIAL LISTING OF ELIGIBLE MEDICAL EXPENSES

GENERAL MEDICAL EXPENSES

Abdominal Supports, if prescribed

Abortion Services, if legal

Acupuncture

Ambulance Hire

Air Conditioner for Allergy Relief (if prescribed by Doctor -

cannot be central air conditioning)

Artificial Limbs/Prosthesis

Alcoholism

Back Supports

Birth Control Pills (if prescribed by a Doctor)

Blood Donor Expenses

Braille Books/Magazines (only the value above the regular price

of the publication)

Car Controls for Handicapped

Chiropodist Services Chiropractic Services

Christian Science Practitioner Services

Convalescent Home Expense (Medical Treatment Only - not

Custodial Care)

Cosmetic Surgery necessary to correct a deformity due to congenital abnormality or one caused by personal injury or

disfiguring disease

Cost of Operations and related treatments

Co-payments you pay

Crutches

Deductibles Dermatologist Fees

Diathermy

Doctors Office Visits

Drug Treatment

Fertilization Services

Gynecological Exams

Hospital Bills

Hypnosis for treatment of illness

Hydrotherapy

Immunizations

Insulin

Invalid Chair and Other Supplies

Kidney Donor Expenses

Lab Expenses

Lactrile by Prescription

Lip Reading Lessons Medical Equipment /Supplies

Midwife Expense

Neurologist Fees

Nurses's Fee (including Room and Board Charges) *

Nursing Home Expenses * Nursing Care *

* - If necessary for medical care

Obstetrician Fees (upon delivery and born within same

Orthopedic Shoes

Osteopath

Oxygen

Pediatrician Fees Physical Therapy

Physician Fees Physical Exams

Podiatrist

Practical Nurse for Medical Care

Prescription Drugs Psychiatric Care

Psychologist Psychotherapist

Reclining Chair with Prescription from Physician

Rental of Medical Equipment

Remedial Reading for Dyslexia

Sacroiliac Belt

improvement.

Sanitarium

"Seeing-eye" dog and its upkeep

Sex Therapy - if received as medical treatment Special Diets if not a substitute for regular diet Special Education for the Blind

Sterilization Fees

Support or Corrective Devices Surgeon Fees

Therapeutic Care for drug and alcohol abuse

Therapy Treatments

Transportation and Lodging Expenses if paid primarily for and essential to medical care

Transplants

Truss

Vasectomy

Vitamins (by prescription)

Well Baby Care Wheelchair

Wigs (prescribed by doctor for hair loss by disease)

Whirlpool baths if Prescribed by doctor and does not increase the value of the residence

DENTAL EXPENSES

Bridges, Crowns, Dentures, Exams, Fillings, Orthodontia, X-rays, Insurance Deductible.

Co-payments you pay

HEARING EXPENSES

Exams, Hearing Devices and Aids (including

batteries)

Special Communication Equipment for the Deaf

VISION CARE Exams, Contact Lenses, Frames, Lenses, Solutions,

Oculist services, Optician services, Optometrist services OTHER HEALTH CARE EXPENSES

Special Schools for handicapped persons - must have specific programs to deal with handicapped.

Special home modifications for handicapped; cannot increase value of the home.

Life fee to retirement home for medical care - contract must allocate an amount to medical fees.

Membership fees in association furnishing medical services, hospitalization and clinical care.

PARTIAL LISTING OF NON-ELIGIBLE MEDICAL EXPENSES

Bottled water

Cosmetics, toiletries, toothpastes, etc.

Custodial care in an institution

Funeral and burial expenses

Health club dues, YMCA dues, steam bath, etc. for purposes of general health and well being, even if prescribed by a physician Household and domestic help (even though recommended by a qualified physician because of an employee's or dependent's

inability to perform physical housework)

Marriage or family counseling

Maternity clothes, diaper service, etc. Membership fees of costs associated with weight loss or smoking cessation programs for purposes of general health and well being.

even if prescribed by a physician Non-prescription drugs

Nursing for newborns; the salary expense of a licensed practical nurse incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth)

Operations: any expense incurred in connection with an illegal operation or treatment

Premiums: automobile insurance premiums including the segment of premiums providing medical coverage for persons injured through accident by an employees car-any life insurance premiums paid for life insurance policies or for policies providing repayment for loss of earnings or accidental loss of life, limb, sight, etc. - any medical or dental insurance premiums. Social activities, such as dance lessons or classes even though

recommended by a qualified physician for general health

Special schools: any expenses incurred for sending a problem child to a special school for anticipated benefits the child may receive from the course of study and the disciplinary

Transportation expense to and from work, even though a physical condition may require special means of transportation.

Uniforms

Unnecessary cosmetic surgery, such as a face lift Vacations for travel taken for purposes of general health, change in environment, improvement of morale, etc., to relieve physical or mental discomfort not related to a particular disease or physical defect Vitamins taken for general health purposes Weight loss and related charges, unless prescribed by a physician to

treat a medical illness (e.g., heart disease). TRANSPORTATION - YOU MAY INCLUDE as medical expenses amounts paid for transportation primarily for and essential to medical care. YOU MAY NOT INCLUDE transportation expenses to and from work, even if your condition requires an unusual means of transportation; transportation expenses if, for non medical reasons only, you choose to travel to another city, such as a resort area, for an operation or other medical care prescribed by your doctor.

LODGING - YOU MAY INCLUDE in medical expenses the cost of meals and lodging at a hospital or similar institution if your main reason for being there is to receive medical care. YOU MAY INCLUDE in medical expenses the cost of lodging (not provided in a hospital or similar institution) while away from home IF the lodging is primarily for and essential to medical care provided by a doctor in a licensed hospital or equivalent and there is no significant element of personal pleasure. The amount you include in medical expenses may not exceed \$50.00 a night for each individual. Lodging expense is eligible for a person who must accompany the individual receiving medical care, for example, a parent traveling with a sick child.

CONSULT IRS PUBLICATION 502 FOR A MORE COMPLETE LISTING OF ELIGIBLE AND NON-ELIGIBLE MEDICAL EXPENSES

DEPENDENT CARE - IMPORTANT RESTRICTIONS

If married, the total payments made in a taxable year, under this and any other Dependent Care Plan, cannot exceed the lesser of your earned income, or your spouse's earned income, during that taxable year. - The expenses are necessary to enable you (and your spouse, if married) to work or actively search for employment. - Your spouse must work outside the home, be a full-time student or be disabled. - Your dependent must be under the age of 13 and must be eligible to be claimed as a dependent on your federal income tax return, or your dependent is physically or mentally incapable of caring for himself or herself (a disabled spouse or elderly parent, for example). - If services were provided outside the home, the dependent for whom services were incurred spends at least (8) hours a day in your household. - The person providing the service will not be claimed as a dependent on your income tax return for the Plan Year in which the service was provided.

CONSULT IRS PUBLICATION 503 FOR ADDITIONAL GUIDANCE.

CITY OF SAN ANTONIO EXTENDED SICK LEAVE PROGRAM

THIS FORM MOST BE RECEIVED BY THE PLAN ADMINISTRATOR

(Date)



Mail this form to:

Rosie Perez Budget & Employee Services Dept. P.O.Box 839966 San Antonio, TX. 78283-3966 Ph: # 207-7291 Fax: 207-2176

WITHIN 30 DAYS AFTER ONSET OF THE DISABILITY. NO BENEFITS WILL BE PAID IF THIS FORM IS RECEIVED AFTER 30 DAYS.

may	B. Return the completed for delay the processing of you act Rosie Perez.	r claim for ben	efits. If you	need assis	stance with this form,
		EMPLOYEE	STATEMENT		
1.	Name: Last	First		Middle	
	Social Security Number		Sex_		
	Date of Birth: Month_	Day	Year_	· · · · · · · · · · · · · · · · · · ·	
2.	Street Address:				
	City	State		Zip	
	Telephone: Area:	Number:			
3.	What is the nature of you	r sickness or in	njury? (Desc If p	ribe complic regnant, giv	cations, if any.) we due date.
4.	What was or will be your	last day at work	? Month	Day	Year
5.	For what period were you of From: Month Day				Year
6.	When were you last treate	d by a doctor?	MonthD	ay_Yea	r
7.	Have you ben released from If yes, when? Month If no, how often do you s	DayYear		lo	•
8.	Please list the name(s) a your illness.	nd address(es) (of hospitals	where you w	were or will be confined
9.	Is this condition due to If yes, explain.	a job related i	llness or inj	jury? Yes_	No
10.	Was your illness or injur Yes No If yes, explain.	y caused by the	wrongful or	negligent a	act of another person?
ADM	EREBY CERTIFY THAT THE ANSW INISTRATOR TO EXAMINE AND S INFORMATION. A COPY OF THIS	ECURE COPIES OF	ANY MEDICAL,	INSURANCE	COMPANY OR OTHER RECORDS

(Signature of Employee)